

EDITORIALS

20. Conn HO, Resnick RH, Grace ND, et al: Distal splenorenal shunt vs portal-systemic shunt: Current status of a controlled trial. *Hepatology* 1:151-160, 1981

21. Fischer JE, Bauer RH, Atamian S, et al: Comparison of distal and proximal splenorenal shunts: A randomized prospective trial. *Ann Surg* 194:531-544, 1981

22. Maillard JN, Flamant YM, Hay JM, et al: Selectivity of the distal splenorenal shunt. *Surgery* 86:663-671, Nov 1979

23. Mutchnick MG, Lerner E, Conn HO: Effect of portacaval anastomosis on hypersplenism. *Am J Dig Dis* 25:929-938, 1980

24. Reynolds TB, Donovan AJ, Mikkelsen WP, et al: Results of a 12-year randomized trial of portacaval shunt in patients with alcoholic liver disease and bleeding varices. *Gastroenterology* 80:1005-1011, 1981

25. Borowsky SA, Strome S, Lott E: Continued heavy drinking and survival in alcoholic cirrhotics. *Gastroenterology* 80:1405-1409, 1981

Cheating in Medical School

AT A RECENT MEETING of the Association of American Medical Colleges there was a depressing report on the existence, nay, the prevalence of cheating in medical schools. A study in two unnamed medical schools (which understandably assured anonymity for the schools and the students) reported that some 58 percent of the medical students admitted to having cheated in medical school and that 88 percent of those admitted to having cheated as undergraduates as well. However, the good news is that only 2 percent of the 58 percent who had cheated were frequent cheaters. The extent to which cheating may or may not be a problem in other than the two unnamed schools is not known.

In today's world of medical science and patient care the personal integrity of a research scientist or a practicing physician is a basic given, upon which the whole structure of the advancement of medical knowledge, its transmission to medical students and others, and its use in the day-to-day care of patients rests. This personal and professional integrity is the sine qua non of patients' confidence in their physicians and the public's trust in the medical profession.

It is likely that some of the relatively small number of frequent cheaters may be incorrigible. In the professional and public interest these should be exposed and expelled from the school or from the profession, even at the expense of the time-consuming and costly legal actions that are almost certain to ensue. But it would seem that for most of the involved students, who usually are highly motivated but who may have cheated occasionally, a maturing process of education and counseling may be all that is necessary to correct the problem. This could and should be an essential faculty responsibility for the training of physicians. After all, there is very little need to cheat

in medical school, and, after all, it is in medical school that students begin to learn what is expected of every member of this learned and trusted profession.

—MSMW

Uncertainties in Distinction of Typical Primary Hyperparathyroidism From Familial Hypocalciuric Hypercalcemia

Our consultants regard the following as worthwhile: blood sugar, to detect diabetes (usually done on an empty stomach); calcium, to detect hyperparathyroidism; cholesterol, to judge the risk of heart disease . . .

—CONSUMERS UNION¹

WIDESPREAD MEASUREMENT of multiple analytes in small volumes of serum has accurately and inexpensively led to a rise in the ascertainment rate for hypercalcemia. Studies in the US² and England³ provide estimates that annual testing would uncover 25 new cases of hypercalcemia a year per 100,000 population. If this case-ascertainment rate were stable over a 40-year period, 1 percent of the population would have a diagnosis of hypercalcemia. In an unknown fraction of these hypercalcemic persons the cause is familial benign hypercalcemia or familial hypocalciuric hypercalcemia (FHH).^{4,5}

FHH is characterized by autosomal dominant transmission with high penetrance for hypercalcemia at all ages. Hypercalcemia is often asymptomatic, hypercalciuria is rare and standard subtotal parathyroidectomy is usually ineffective in correcting the hypercalcemia. Usual complications of chronic hypercalcemia and hypercalciuria, such as nephrolithiasis, impairment of urine-concentrating ability,⁶ and reduced glomerular filtration rate, are uncommon. FHH is associated with abnormal function of the kidneys (high tubular resorption of filtered calcium⁷) and of the parathyroids (mild hyperplasia⁸ despite high concentrations of ionized calcium in blood). Cellular insensitivity to extracellular ionized calcium in these two affected organs and perhaps in other organs as well^{9,10} might account for this disorder. Cellular insensitivity to extracellular ionized cal-